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ARNOLD BROWN WILL BE APPOINTED NCI DIRECTOR; RAUSCHER, STAFF "COULDN'T BE MORE PLEASED"

Arnold L. (Bud) Brown, chairman of the Dept. of Pathology & Anatomy at the Mayo Clinic and Mayo Medical School, will be the new NCI director and director of the National Cancer Program. Brown's appointment probably will be effective Jan. 1, provided certain administrative details can be implemented by then, and also provided that President Ford formally makes the appointment.

Benno Schmidt, chairman of the President's Cancer Panel, intends to recommend Brown's appointment to President Ford, *The Cancer Letter* has learned. The task of advising the President on the selection of the NCI director is one of the official assignments of the Panel. Schmidt declined to make any comment at this time.

Frank Rauscher's last day as director will be Oct. 29. He will start his new job as senior vice president for research with the American Cancer Society on Nov. 1. Deputy Director Guy Newell probably will

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In Brief

JENSEN, SELIKOFF RECEIVE ACS NATIONAL AWARDS; CCIRC SCHEDULES MINI-SYMPOSIUM

NATIONAL AWARDS, the American Cancer Society's highest honor, were received by Irving Selikoff and Elwood Jensen at the ACS annual dinner last week. Selikoff is director of the Environmental Sciences Laboratory at Mount Sinai School of Medicine; Jensen is director of the Ben May Laboratory for Cancer Research at the Univ. of Chicago. Selikoff was honored for his "pioneering exploration of the relationship between the environment and cancer," Jensen for "many years of important biomedical research, especially for identification of the estrogen binding capacity of certain mammary tumors." . . . **A "MINI-SYMPOSIUM"** on treatment of infection in the cancer patient will be conducted by the Cancer Clinical Investigation Review Committee Nov. 9, 9 a.m. to noon, at NIH Bldg 31 Conference Room 8. . . . **CANCER REHABILITATION** workshops are scheduled for Oct. 28 at Roswell Park on psychosocial aspects of cancer, management of communicative disorders, occupational therapy and rehab and physical therapy. Registration fee is $6. Phone 716-845-3399. . . . **CURRENT MANAGEMENT** for Hodgkin's disease and non-Hodgkin's lymphoma is the topic of a continuing medical education program sponsored by the Hahnemann Medical College Dept. of Radiation Therapy Nov. 18-19. Write to Carl Karsch at Hahnemann, 230 N. Broad St., Philadelphia 19102. Registration fee is $100. . . . **STANFORD RESEARCH** Institute has received a $134,690 contract from the National Institute for Occupational Safety & Health to study the risk of cancer among plywood, pulp and paperworkers. This was one of the projects pushed by Congressman David Obey.

MAYO'S ARNOLD BROWN, TOP EXPERIMENTAL PATHOLOGIST, TO BE NEW NCI DIRECTOR

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serve as acting director until Brown takes over.

Rauscher said that he "couldn't be more pleased" that Brown has agreed to take the job. "It makes me feel a lot better about leaving, knowing he will take over." NCI staff members he has discussed it with have been unanimous in their enthusiastic approval of Brown, Rauscher said.

Brown, 50, confirmed that he had agreed to accept the appointment if the President offers it to him. There is one condition—the job must include an appointment as a medical officer in the Public Health Service Commissioned Corps. As an MD, Brown is eligible for such an appointment which would qualify him for a salary of $10-12,000 more than the $39,-000 limit now in effect for government executives. "That's the only way I could afford to take the job," Brown told ***The Cancer Letter.***

HEW Assistant Secretary for Health Theodore Cooper has agreed to appoint Brown to the Corps, the only requirement being that he pass the physical examination. "I'm in good health as far as I know," Brown said. He stays in shape by playing tennis.

Brown is one of the nation's leading experimental pathologists, perhaps No. 1 in that field, with about 220 papers to his credit. It was with that scientific standing that he was appointed to the National Cancer Advisory Council in 1970, and he continued on that body when it was expanded into the National Cancer Advisory Board in 1972. He was a member of the NCAB Subcommittee on Carcinogenesis, and he continued as a consultant to the subcommittee after his term on the Board expired. He is a member of the National Committee on Heart Disease, Cancer & Stroke, and serves as a consultant to the U.S. District Court in the case involving the Reserve Mining Co.'s dumping of asbestos waste into the Great Lakes.

When the Food & Drug Administration last year asked for NCI's assistance in evaluating the evidence of the carcinogenicity of cyclamates, Rauscher asked Brown to head that effort. It was a tough job involving review of the various cyclamate studies by teams of pathologists, epidemiologists and statisticians. Brown led the committee members through the reviews and followup discussions into a consensus on each issue involved. They concluded that present techniques do not permit definitive determination of cyclamate's carcinogenicity but that it could very well be considered a weak carcinogen. FDA subsequently decided to continue its ban on the chemical's use in food.

When NCI decided to establish the Clearinghouse on Environmental Carcinogens, Brown was named chairman. NCI will have to find another chairman now. First meeting of the Clearinghouse is Nov. 8-9.

It was more than Brown's scientific credentials which led to his selection by Schmidt and his colleagues. One of the most important roles demanded of the NCI director is that as spokesman for and salesman of the National Cancer Program in dealing with the scientific community, Congress and the public. Brown has the same type of open, honest, articulate manner that enabled Rauscher to fill that role so successfully.

Brown was born in Wooster, Ohio, Jan. 26, 1926. He attended public schools in Michigan and Indiana and did his undergraduate work at the Univ. of Richmond. He obtained his MD degree at the Medical College of Virginia, and was a visiting student at the Bernard Baron Institute of Pathology in London. His internship, residency, and pathology residency were at Presbyterian Hospital in Chicago. He was a post doctoral fellow of the National Heart Institute, worked as assistant attending pathologist at Presbyterian-St. Luke's Hospital and as an instructor in pathology at the Univ. of Illinois College of Medicine.

Brown joined Mayo Clinic in 1959 as a consultant in the Section of Anatomic & Experimental Pathology and as an instructor in pathology. He became an assistant professor in 1963, associate professor in 1967, and chairman of the department in 1968. He was appointed professor of pathology at the Mayo Graduate School of Medicine in 1971 and at Mayo Medical School in 1973.

Brown is married to the former Betty Jane Simpson, whom he met when both were students in Richmond. They have five children—Arnold L. III, born in 1951; Anthony C., born in 1954; Allen W., born in 1956; and Lisa K. and Fletcher S., born in 1961.

NCAB TO HEAR PROGRAM REVIEWS, TRY AGAIN ON NEW CANCER ACT REVISIONS

The annual NCI program review will be presented to the National Cancer Advisory Board at its meeting Nov. 15-16. The entire meeting is open and will start at 9 a.m. each day.

Presentations will include:

- Prophage induction test-carcinogenesis bioassay, by Michael Yarmolinsky, Litton-Bionetics, Frederick Cancer Research Center.
- In-vitro carcinogenesis tests, Bruce Ames, Univ. of California.
- NCI Clearinghouse on Environmental Carcinogenesis, James Peters, NCI.
- NCI environmental epidemiology program, Joseph Fraumini, NCI.
- Supportive clinical care activities: (A) Laminar air flow units and associated technology, Edward Henderson, Roswell Park Memorial Institute; (B) Platelet transfusion treatment, Ronald Yankee, Farber Comprehensive Cancer Center; (C) White cell transfusion treatment, Emil Freireich, M.D. Anderson; (D) Resources for supportive care activities, Guy Newell, NCI; (E) Prevention of lung, bladder

and breast cancer by vitamin A and its synthetic analogs, Michael Sporn, NCI; (F) Clinical application: CEA assay, Ronald Herberman, NCI; (G) Problems of technology transfer, William Terry, NCI; (H) Cancer control technologies, Diane Fink, NCI; (I) Patterns of clinical care, Simon Kramer, Thomas Jefferson Univ.; (J) Management of acute leukemia patients, Max Myers, NCI.

Denman Hammond, chairman of the Board's Subcommittee on Centers & Construction, will report on that group's activites.

Finally, the Board will try again to develop its recommendations for revisions to the National Cancer Act. At its September meeting, the Board could not resolve the question of whether or not it should ask for the removal of the $5 million limit on core grants to centers. Another controversial question the Board did not get to was what to do, if anything, about seeking exemption from Health Service Agency review. A number of other less controversial suggestions for incorporation into the Act still must be considered.

The Board will be asked to reconsider the one item it did approve—the authorization levels for 1978, 1979 and 1980 fiscal years. The Board subcommittee charged with developing Act revision recommendations had agreed on one set of figures. But Board member Mary Lasker, who was not at the September meeting, had urged higher levels. The Board compromised on figures between the two. Lasker, however, is insisting on the higher levels and will ask the Board to vote on them again.

COMMITTEE APPROVES RFP SUGGESTIONS FOR IMMUNODIAGNOSIS RESEARCH AREAS

Suggestions for new RFPs developed by NCI's Immunology Program immunotherapy and immunobiology advisory committees were reported in the Oct. 8 issue of ***The Cancer Letter***. Suggestions by the program's immunodiagnosis committee, not available at that time, are reported below.

The committees suggest general areas of research, and only a limited number of those suggestions turn up as RFPs. NCI staff selects those areas to be pursued in contract-supported research, and staff members write the RFPs.

A majority of the members of the Immunodiagnosis Committee supported research in:

—Diagnostic applications of monocyte function in cancer patients.

—Cell-mediated reactivity of normal individuals to human tumor associated antigens, in vitro specific augmentation of cell-mediated cytotoxic reactions to human tumor cells and human tumor-associated antigens.

—Bacterial antigens as tumor markers.

In reviewing expiring contracts, the committee recommended further support for:

—Innovative techniques or improvements of existing assays for cell-mediated immunity.

—Development of new in vitro techniques to evaluate cell-mediated immunity in intact tumor cells.

—New methods for isolation and characterization of tumor associated antigens.

—Application of new immunological techniques to iso-enzymes.

—New markers for subpopulations of T and B cells.

—Detection of antibodies to autologous human tumor cells (with evidence for existing antibody a prerequisite).

—Procurement of tumor serum serial specimens and serum specimens from cancer patients (with an emphasis on procurement of large volumes).

Among areas discussed but not supported by the committee were general CEA research and development; study of immunosuppressive factors in the sera of cancer patients; and methods for isolation and preservation of lymphocytes for reproducible reactivity in immunologic tests.

The Immunology Program supported $3 million worth of contracts in fiscal 1976.

UCLA SO NEAR AND YET—MAYBE—SO FAR FROM COMPREHENSIVE CENTER STATUS

UCLA's cancer center may be closer than ever to recognition as the 19th comprehensive cancer center. Director Richard Steckel and his staff have worked diligently to achieve that recognition, and in the minds of most NCI staff members involved in the Centers Program, they deserve it.

However, factors which have nothing to do with the excellence of the UCLA program nor how deserving it may be of comprehensive status could work to delay that recognition for several more months, and perhaps indefinitely.

It has been a year since the National Cancer Advisory Board gave its conditional approval to UCLA as a comprehensive cancer center. The Board in its review noted certain deficiencies but agreed that once those deficiencies had been corrected, the NCI director could extend comprehensive designation to UCLA without further Board action.

NCI staff last week made their "final" site visit to UCLA. "Those deficiencies by and large have been corrected," said William Walter, director of the Centers Program. "The institutional commitment is strong. My feeling is that they are ready."

Walter emphasized that he had not yet seen the reports of the staff members who accompanied him on the visit. They looked closely at the radiotherapy and cancer control programs. Those reports will be included with Walter's for submission to NCI Director Frank Rauscher this week.

The problem lies with the continued and adamant determination by the White House that the total number of comprehensive centers will not exceed 21. The Office of Management & Budget reemphasized

that policy at its budget hearing with NCI. Some NCI executives feel that announcement of UCLA as No. 19 so soon after might be interpreted by OMB as flaunting NCI's disregard for Administration policy, since it would leave openings for only two more centers for the rest of the country.

Congress has expressed interest in more widespread distribution of comprehensive cancer centers, another factor that doesn't help UCLA since the USC-Los Angeles County complex is one of the 18 existing comprehensive centers.

Finally, although Rauscher probably would ignore the OMB and congressional pressures under normal circumstances, as the Cancer Act gives him the authority to do, the situation now is anything but normal. If Rauscher does make the announcement before he leaves, it would come just days before the election and could be interpreted as another vote-grabbing, passing-out-the-federal-goodies effort by President Ford. (It would be ironic if Ford did pick up votes in the key state of California for an action which he had opposed behind the scenes.)

Rauscher has worked hard to keep such political factors out of the Cancer Program, especially in the recognition of comprehensive centers. If Rauscher decides that the announcement should not be made before the election, then it would be up to Guy Newell, who will be acting director until Arnold Brown is on the scene. Newell is independent enough to do that, but he may not feel it is wise at a time when OMB is drawing up next year's budget, or he may feel it is a decision that should be made by the permanent director. And Brown justifiably may determine that a waiting period would be in order before leaping into the controversy.

Will Rauscher ignore possible criticism from both sides and go ahead with the announcement as his last official act? Will Newell, given the chance, stand up to the OMB bullies? Will Jimmy Carter defeat Ford, bringing up the prospect of a house cleaning at OMB? Tune in after the election for the answers.

BYRD CALLS FOR TAR-NICOTINE LIMITS, MAMMOGRAPHY SUPPORT, BLOOD BANK

Benjamin Byrd Jr., retiring president of the American Cancer Society, told the Society's annual meeting that "saving lives . . . is the bottom line in everything we do or attempt," and he outlined four immediate and urgent measures toward that aim:

1. A federal law placing a ceiling on the tar and nicotine content of all cigarettes.
2. Strong support of mammography for women of all ages who should have it.
3. Support for the Toxic Substances Act passed by the Congress.
4. Development of a nationwide voluntary blood program for cancer patients.

On point one, Byrd, who is clinical professor of surgery at Vanderbilt Univ., noted that a study by E. Cuyler Hammond, chief epidemiologist of ACS, showed that people who smoked low tar and low nicotine cigarettes had fewer deaths from lung cancer and heart disease. Though nonsmokers had far less deaths than those who smoked the lower tar and nicotine cigarette, Byrd said that legislation to bar high tar and high nicotine cigarettes would be a step toward lower mortality from cigarettes.

On point two Byrd referred to the recent controversy about mammography and declared:

"Some scientists think that radiation is dangerous even in the tiny amounts used to examine the breasts by x-ray. This is an opinion, it is not an established fact. Currently less than one rad of radiation is necessary in mammography—and there are no definitive data about the effects of radiation under 100 rads."

Byrd added that the 27 Breast Cancer Detection Demonstration projects sponsored by ACS and NCI "have been an immense success." He noted that they have uncovered 1,000 breast cancers among the 275,000 asymptomatic women over 35 who were examined at these centers. "Among those women in the projects who have been treated for breast cancer, there have been no deaths," Byrd said.

On point four Byrd said that the Colorado division of the ACS had pioneered on a blood program for the needs of cancer patients

SELECTED ABSTRACTS OF PAPERS READ AT THERAPEUTIC RADIOLOGISTS MEETING

The following abstracts were selected from papers presented at the 18th annual meeting of the American Society of Therapeutic Radiologists this month in Atlanta. Complete papers from which the abstracts published here were derived are available; write to Charles Honaker, director of public relations, American College of Radiology, 20 N. Wacker Dr., Chicago, Ill. 60606.

"TOTAL" THERAPY OF SMALL CELL LUNG CANCER – Ralph Johnson, C. Harry Kent and Harmar Brereton, NCI

Single modality therapy for small cell cancer of the lung has been disappointing and we have likewise abandoned the sequential use of radiotherapy and chemotherapy. In the past two years, 31 consecutive patients received simultaneous irradiation of bulk disease (primary and metastatic), prophylactic whole brain irradiation, and combination chemotherapy in nearly bone marrow-ablating doses. A complete remission rate of 90% has been achieved with the three-month treatment program. Remissions of encouraging duration without maintenance therapy suggest curative treatment may become a potential for this almost uniformly fatal type of lung cancer.

CLINICAL REPORT ON THE TREATMENT OF LOCALLY ADVANCED LUNG CANCER – Zbigniew Petrovich, Maimu Ohanian, William Mietlowski and James Cox, Wadsworth Hospital Center

This paper discusses the results of the treatment of 345 patients entered in the VALG Protocol 13L. The study was activated in March 1972, and closed for patient accession March, 1975. All patients had a histologic diagnosis of primary lung cancer, considered clinically nonresectable or inoperable. Patients were equally randomized into two groups, radiotherapy alone or radiotherapy with chemotherapy.

The analysis of the data included: Treatment regimen, radiation dose, initial performance status, performance status change, cell type,

duration of survival, quality of survival, age and previous surgery. The strongest influence on median survival was the level of radiation dose. The patients treated with radiotherapy and chemotherapy showed improvement in performance status more frequently than the patients treated with radiotherapy alone. The length of survival for both groups is similar.

MULTIMODALITY THERAPY FOR METASTATIC OSTEOSARCOMA — James Cassady, Ralph Weichselbaum, Norman Jaffe, Robert Filler, and Hugh Watts, Harvard Univ.

The therapeutic efficacy of high dose methotrexate therapy with citrovorum rescue administered every three weeks as adjuvant therapy for osteosarcoma has been demonstrated. More recently, the efficacy of this program on a weekly basis has become apparent. However, patients with osteosarcoma who present with metastatic disease or develop metastasis despite adjuvant therapy continue to pose difficult patient management decisions. We describe the results of an aggressive multimodality plan for osteosarcoma patients with metastases utilizing surgery, irradiation and weekly high-dose methotrexate therapy with citrovorum rescue developed at the Joint Center for Radiation Therapy, Sidney Farber Cancer Center and Children's Hospital Medical Center. Of 23 patients with metastasis who received weekly high dose methotrexate, 12 underwent irradiation to either regions of completely excised tumor (group 1) or regions of known residual disease (group 2). Five of six patients in group 1 are alive without disease and six of six patients in group 2 are without evidence of disease, and all of these have control in irradiated sites. These were encompassable in small volume high dose portals. Two of six were not encompassable with high dose portals and failed in irradiated sites. The entire group of 23 patients is analyzed for survival and sites of failure and an optimum therapeutic regimen outlined. A radiation dose response relationship for osteosarcoma related to tumor volume is suggested and correlated with previous known laboratory and clinical data.

THE TREATMENT OF CRANIOPHARYNGIOMAS — Allen Lichter, William Wara, Glenn Sheline, Charles Wilson, and Jeannette Townsend, Univ. of California

The optimal treatment for craniopharyngiomas is widely disputed. Many authors recommend total surgical removal when possible, while others advocate decompression followed by radiation therapy. We have reviewed 34 cases of craniopharyngiomas seen at the Univ. of California (San Francisco) from 1956 to 1973. Eighteen patients were treated with surgery plus radiotherapy and 16 with surgery alone. Minimum followup time is three years with 14 patients followed from 5-9 years and eight patients followed for 10 years or more. It appears that radiation therapy prolongs disease-free interval and may lead to permanent control.

EARLY NODAL AND EXTRA-NODAL NON-HODGKIN'S LYMPHOMAS — Salitha Reddy, Virendra Saxena, and Frank Hendrickson, Rush-Presbyterian-St. Luke's Medical Center

There were 53 Stage I and 38 Stage II non-Hodgkin's lymphomas treated with curative radiotherapy through the years 1964 to 1974. The actuarial five-year survival rates for Stage I and II were 88% and 49% respectively. Their recurrence-free survival rates were found to be 57% for Stage I and 28% for Stage II at the end of five years. The sites of first recurrence were also evaluated: 14 out of 22 Stage I and 18 out of 27 Stage II patients recurred in nodal areas as their first site of recurrence. In 40%, this was in contiguous nodal areas only. The influence of this on proposed management will be discussed. Extra-nodal non-Hodgkin's lymphomas, survival and recurrence-free survival rates at five years were 92% and 82% for Stage I and 47% and 28% for Stage II. The survival and recurrence-free survival rates were evaluated according to the histology.

MEDULLOBLASTOMA: A REVIEW OF THE L.D.S. HOSPITAL EXPERIENCE WITH IRRADIATION THERAPY — Richard Brown, Leonard Gunderson, and Henry Plenk, Arizona Medical Center

A review of 14 patients with an initial diagnosis of medulloblastoma treated with irradiation therapy is presented. Followup data is available on all patients. When one evaluates those patients who were treated with total CNS irradiation, an excellent five-year survival of approximately 70% is observed. The point of significance is that the dose to the spinal axis was in the range of 2500 rads for the majority of the survivors with a boost to the posterior fossa between 4500 and 5000 rads. Only one patient had metastatic disease, and that was a patient who had a ventricular atrial shunt placed initially for control of increased intracranial pressure. This survival data adds to already published data from Hope-Stone and others reporting excellent five-year survival with total CNS irradiation and is contradictory to the reports of approximately 40% five-year survival. The implications of the following review is that one can question the necessity of taking all patients with medulloblastoma to 3500 rads to the spinal column. We would suggest that included in the routine work-up would be Millipore evaluation of the CSF, and if negative, use a low dose to the spinal column of approximately 2500 rads. Thus, decrease the potential for spinal column arrest in the young group of patients.

PREGNANCY FOLLOWING OOPHOROPEXY AND TOTAL NODAL IRRADIATION IN WOMEN WITH HODGKIN'S DISEASE — Sarah Donaldson, Olivier Le Floch, and Henry Kaplan, Stanford Univ. School of Medicine

During the past decade at Stanford Univ. Medical Center, in an attempt to protect ovarian function in young female patients irradiated for Hodgkin's disease, oophoropexy has been performed at the time of surgical staging. When pelvic irradiation is administered, a 10 cm. thick lead block is used to shield the ovaries in the midline. With this technique, two-thirds of females have retained ovarian function, and nine women who underwent oophoropexy prior to high dose pelvic irradiation have become pregnant. Six patients have given birth to eight babies. An additional two patients have had therapeutic abortions and one a spontaneous abortion. The minimum radiation dose to the ovaries was 350 to 400 rads in 39 to 46 days. No abnormalities have been observed in the children; no ectopic pregnancies have occurred.

COMPLICATIONS OF TREATMENT OF HODGKIN'S DISEASE — Hipolito Poussin-Rossilo, Lourdes Nisce, and Burton J. Lee, Memorial Sloan-Kettering Cancer Center

The use of wide field irradiation for the management of Hodgkin's disease and the common sites of involvement by disease make it necessary to include many normal structures within the treatment volume. Complications have been previously described by several authors. The purpose of this study is to analyze the complications of the use of the "3&2" technique in regard to cardiac, pulmonary, and thyroid diseases induced by this approach. In addition, the incidence of Herpes Zoster in relation to sequential irradiation and chemotherapy, and the influence of splenectomy will be reviewed. Since 1969, the management of Stage III patients at Memorial Hospital has been total nodal irradiation employing split-course and sequential irradiation techniques, the so-called "3&2" technique. A dose of 3500 to 4000 rads is delivered in two phases in an overall period of 11 to 12 weeks. Of the 131 patients treated between 1969-1974, two developed pericarditis (1.5%), six pneumonitis (4.6%), five hypothyroidism (3.8%). The incidence of Herpes Zoster in patients receiving total nodal irradiation following a splenectomy is 91% and the onset is five to 10 months following treatment. The lower incidence of pericarditis and pneumonitis as compared to other series, is primarily the result of the ability to shrink fields after the first phase of treatment.

EPITHELIOID GRANULOMAS ASSOCIATED WITH HODGKIN'S DISEASE — CLINICAL CORRELATIONS — Edmund Sacks, Sarah Donaldson, Janine Gordon, and Ronald Dorfman, Stanford Univ. Medical Center

Records of 512 consecutive patients with biopsy proven Hodgkin's disease initially evaluated and treated at Stanford Univ. Medical Center between 1968 and 1973, were examined. Sixty-nine of these patients with histologically verified epithelioid (non-caseating) granulomas in addition to Hodgkin's disease were analyzed separately from the non-granuloma group. The two groups were equivalent with regards to age, sex, stage and histological subclassification.

Survival and relapse-free survival data with followup from two to seven years are 74.4% and 63.1% for the non-granuloma group and 88% and 68.3% for the granuloma patients. These parameters are not significantly different for the patients with granulomas ($p > 0.05$).

Concomitant granulomas and Hodgkin's disease were found in 2/33 liver biopsies, 14/56 spleens with granulomas had Hodgkin's disease. Of those 18 patients relapsing after initial therapy, two extended to areas previously involved with granulomas. Fifteen patients demonstrating hepatic granulomas without concomitant Hodgkin's disease at initial staging did not receive prophylactic hepatic therapy. Six relapsed, but none primarily in the liver.

In contrast to other authors, we conclude that 1) epithelioid granulomas associated with Hodgkin's disease do not portend significant alteration in survival or relapse-free survival, and 2) the presence of granulomas in an organ does not herald involvement nor subsequent extension by Hodgkin's disease into that organ.

EWING'S SARCOMA: PROPHYLACTIC WHOLE-LUNG IRRADIATION – Phillip Smith, Dempsey Springfield, and Rodney Million, Univ. of Florida

Eighteen patients with non-metastatic Ewing's sarcoma have been treated from 1966 to 1975 at the Univ. of Florida. Prior to 1972, eight patients received irradiation and adjuvant chemotherapy. Of this group, five have failed, four with metastatic pulmonary disease as a part of their recurrence. Since 1972, 10 patients have received a planned course of prophylactic whole-lung irradiation. In this group, there have been three failures with skeletal metastases, but no patients with pulmonary disease to date. At the dose rate used (1500 rads in 15 fractions), there have been no acute or late pulmonary complications. Long-term functional results of controlled primary sites have also been evaluated, these results are good.

WHOLE LUNG IRRADIATION IN THE PEDIATRIC AGE GROUP: LOW-DOSE VERSUS CONVENTIONAL FRACTIONATION, WITH MULTI-DRUG CHEMOTHERAPY – Beryl Chabora, Paul Lattin, M. Lois Murphy, and Arnold Herskovic, Memorial Sloan-Kettering

Whole-lung irradiation has been documented in the literature as an effective control of pulmonary metastases in the pediatric age group. Prior to January 1975, daily fractions of 200 rad per day were used at Memorial Hospital for this patient group. However, combined with the multi-drug chemotherapy protocols so often used in this group, such treatments resulted in a high percentage of severe complications. Since January 1975, a radiation regimen of 100 rad per day, to a total dose of 1400 rad, has been utilized in these cases, encompassing one or both lung fields as the clinical situation dictated. Ten patients have been so treated and followed for a minimum of one year. The local tumor control in this group, as well as the complication rate, has been compared to 13 similar cases treated prior to January 1975. Radiation factors, including time-dose relationships, and chemotherapy regimens, will be presented and discussed for both groups of patients.

HODGKIN'S DISEASE STAGE I AND II: A COMPARISON BETWEEN TWO DIFFERENT TREATMENT POLICIES – Thomas Stoffel and James Cox, Walter Reed Army Medical Center

A retrospective analysis was performed on 145 patients with Stage I and II Hodgkin's disease treated over a 10-year period. Eighty-three patients (group A) received radiotherapy according to the present policy: all Stage I-B and II-B and all mixed cellularity and lymphocytic depletion types received total nodal irradiation while Stage I-A and II-A nodular sclerosing and lymphocytic predominance cases received irradiation to a mantle field and to the para-aortic lymph nodes. Sixty-two patients (group B) received a mantle field without systematic irradiation of the para-aortic lymph node chains. The characteristics of the two groups were roughly comparable in age range, sex, staging, histopathologic subtypes and total irradiation doses. All patients had lymphangiograms although not all underwent staging laparotomies. The staging laparotomy did not appear to have an influence within each group. The extent of irradiation did affect both the incidence of further manifestation of disease as well as survival rates. The incidence of lymph node extension, organ extension and local recurrence was 5%, 2%, and 6% for group A patients while for group B it was 23%, 14% and 3%, respectively. Especially notable was the pelvic nodal extension in 6 of 27 patients with mixed cellularity in the group B patients who did not receive pelvic irradiation. With an average followup of 3.25 years, 87% of group A patients are relapse-free with an over-all survival rate of 96%. With an average followup of 4.5 years, 60% of group B patients are relapse-free with an over-all survival rate of 65%.

SOURCES SOUGHT

Synopsis NICHD-76-39

Title: *Case-control study of pituitary adenomas and the role of oral contraceptives*

Organizations having research capabilities and interest in whether or not oral contraceptives play an etiological role in the development of pituitary adenomas or whether the relationship is biased by other factors are invited to submit complete information to the procuring office listed below. The government knows of only one source who has the available subjects and can meet the criteria listed herein to participate in a proposed project, which is the Univ. of Southern California. Other organizations that believe they have the capability to compete for or participate in this project should furnish the following information.

1) Evidence of a minimum 50 traceable patients with pituitary adenoma in women with "post-pill" secondary amenorrhea and women whose secondary amenorrhea has not followed the discontinuation of oral contraceptives. 2) Expertise in endocrinology and other relevant disciplines for the evaluations, diagnosis, and management of women suspected of having pituitary adenomas. 3) Availability of non-hospital subjects to serve as controls. 4) Epidemiologic expertise available for participation and professional qualifications of other potential participants. This is not a request for proposal and responses should not include budget information. Responses should cite the Synopsis NICHD-76-39.

Write to: Office of Grants and Contracts
National Institute of Child Health and Human Development, Landow Bldg
Rm C-629, Bethesda, Md. 20014
Attn: R.A. Wagner

SOLE SOURCE NEGOTIATIONS

Proposals are listed here for information purposes only. RFPs are not available.

Title: Support Services for field studies
Contractor: Westat Inc., Rockville, Md.

Title: Bay Area (San Francisco) Resource for cancer epidemiology
Contractor: California Dept. of Public Health.

CONTRACT AWARDS

Title: In vitro cultivation of normal prostatic epithelial cells
Contractor: Tissue Culture Assn. Inc., Lake Placid, N.Y., $331,097.

Title: Development of animal model for oat cell carcinoma of the lung
Contractor: Dartmouth College, $499,916.

Title: Markers for evaluation of preneoplastic lesions in the respiratory tract
Contractors: Univ. of Chicago, $452,560, and Baylor College of Medicine, $313,280.

The Cancer Letter—*Editor* JERRY D. BOYD

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